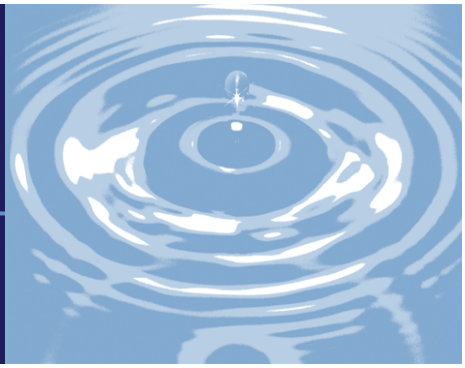
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES



DISASTER PREPAREDNESS RESPONSE AND RECOVERY PLAN FOR THE STATE OF NORTH CAROLINA

January 2010

MH | DD | SAS

division of mental health | developmental disabilities | substance abuse services

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I. OVERVIEW

A. Record of Changes

Previous Date	Date of Change	Change Made By
2004-2005	January 2005	Disaster Coordinator, DMH/DD/SAS
2010	January 2010	Disaster Coordinator, DMH/DD/SAS

B. Distribution List

Agency	
DMH/DD/SAS	Executive Leadership Team
Department of Health and Human Services	Office of the Secretary
Department of Health and Human Services	Office of Citizen Services
Department of Public Instruction	
Local Management Entities	
NC Disaster Response Network	
Consumer and Family Advisory Council	
Department of Crime Control and Public Safety	Division of Emergency Management

C. Introduction

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) provides leadership in addressing the behavioral health needs of individuals affected by natural, biological, or human-caused disasters. This disaster preparedness, response and recovery plan is applicable to all such hazards and describes the structure, communications, expectations, resource utilization and procedures required for DMH/DD/SAS to perform its public behavioral health authority role in such an event.

The Division and its related state and local behavioral health agencies must be prepared to serve broader populations of individuals not typically eligible for public behavioral health services. Therefore, response to the needs of individuals in disasters requires

(a) Development of local community infrastructure and
(b) Identification of funding and other resources to support all individuals impacted by the disaster

This revised plan newly recognizes and integrates public education efforts as an important capacity in responding to community needs before and after disaster and places emphasis on cultural competence of services offered. Further, in addition to programmatic foundation, this plan describes infrastructure and staff resources for emergency preparedness and response that reflect higher expectations for interagency coordination and collaboration in the interest of North Carolina's residents.

This plan was reviewed by members of the North Carolina Psychological Association Disaster Response Network, Piedmont Behavioral Health Peer Support Specialists, and the Division of Mental Health, Developmental Disability, and Substance Abuse Services Executive Leadership Team and staff.

This plan is a living document and can be modified to incorporate emerging best practices in disaster behavioral health.

D. Statutory Authority

The Robert T. Stafford Disaster Relief and Emergency Assistance Act and Miscellaneous Directives of P.L. 100-707 establishes the requirements that State Emergency Preparedness Offices plan for providing mental health crisis counseling services in human-caused or natural disaster response and recovery. Section 416 of this act specifically addresses the mental health function. The law states:

The President is authorized to provide professional counseling services, including financial assistance to state and local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.

North Carolina General State Statute 166A-6, the North Carolina Emergency Management Act, Article 1 of the North Carolina Emergency Management Act of 1977 states that in a state of disaster, the Governor shall have the power "to utilize all available State resources as reasonably necessary to cope with an emergency, including the transfer and direction of personnel or functions of State agencies or units thereof for the purpose of performing or facilitating emergency services." The Division operates as a support agency under Emergency Support Function 6-Sheltering, and Emergency Support Function 8-Health and Medical.

E. Purpose

This plan outlines the responsibilities of the state and local public behavioral health system for assisting residents with their emotional needs in all phases of natural, biological, or human-caused disasters. Disaster behavioral health services can help mitigate the severity of adverse psychological effects of the disaster and help restore social and psychological functioning for individuals, families, communities, and emergency responders. This plan describes how the behavioral health response begins at the local level and transitions to state and federal levels when the capacity to respond at the previous level has been exceeded. The behavioral health system recognizes that preparedness, response and recovery efforts must be designed and delivered to meet the needs of:

- Survivors.
- Individuals with special needs.
- Emergency responders.
- Other members of the community who may require assistance to reduce the incidence of adverse and long-term behavioral health outcomes after an event.

F. Guiding Principles

1. Disaster behavioral health is part of a larger, multi-layer, multi-disciplinary disaster response. Disaster behavioral health responders work in concert with health care providers, public health, emergency management, first responders, social service agencies, peers, schools, faith based disaster responders and Voluntary Organizations Active in Disasters (VOAD).

2. The first response to a disaster occurs locally; therefore, the capacity to respond to the psychological effects of disaster must be organized and implemented at the local level. Local planners understand the cultural, social, and psychological needs of people in their area. The local plan builds on the strengths of our communities.

3. The local public behavioral health disaster response is organized and coordinated via the local management entities (LMEs). The State recognizes that local behavioral health disaster resources are limited or may be overwhelmed if the effects of the disaster are severe or widespread. Coordination of human resources within an LME's catchment

area or within a larger region facilitates mutual aid and the pooling of additional resources, if needed.

4. State level involvement in the behavioral health response to disaster builds upon the structure and organization of the local response, including mobilization of additional human resources. The state will augment, not replace, community structures already in place to deliver disaster behavioral health services.

5. Federal level involvement is requested when local and state resources are insufficient to mount initial and/or ongoing behavioral health response.

6. Disaster behavioral health interventions may be systemic and long term, with the goal of restoring or rebuilding the social fabric of a community.

7. Individual disaster behavioral health services must be appropriately delivered; suitable for the type, scope, and phase of the disaster; and adjusted accordingly to be gender and culturally sensitive, linguistically, and developmentally appropriate.

8. Interventions during disaster response and recovery should be based on accepted professional standards and practices, to the extent possible. Interventions directed at treatment of trauma or disaster-related problems should be evidence-based when possible.

9. All publicly funded DMH/DD/SAS providers have a duty to respond if possible. If requested to respond, the agency shall indicate their capacity to respond. If the agency's capacity is exceeded by the need, the LME or DMH/DD/SAS shall document this and request additional resources to augment the services.

10. When a federally funded Crisis Counseling Program (CCP) is implemented, these disaster behavioral health services shall be free, practical, confidential and available at places that are most convenient to the persons in need of assistance, such as their place of residence, their community or other neutral sites.

11. Disaster behavioral health responders shall be trained in disaster behavioral health utilizing the Red Cross Training, Psychological First Aid, Disaster Response Network (DRN), Disaster Mental Health Training, or Critical Incident Stress Debriefing (CISD). Responders that provide Crisis Counseling Program services shall be familiar with Crisis Counseling Program principles, expectations and skills. Also, per FEMA requirements, responders will be trained in Incident Command Structure/National Incident Management System courses 100, 200 and 700.

G. Situation and Assumptions

1. Situations

a. North Carolina is subject to many potential disasters that could endanger large numbers of people. The most likely risk is for weather related events such as tornadoes, flooding, hurricanes and severe winter weather that are oftentimes associated with power outages. North Carolina also has the risk of hazardous materials disasters due to local nuclear power plants, trains that carry and companies that store hazardous materials. Although less common, terrorism is a reality in current times and would have great impact on large segments of the population. This "all hazards" plan can also be modified during a pandemic influenza event by activating the Continuity of Operations Plan (COOP) and using the state web based emergency management communication tool WEB EOC for social distancing during the response phase.

b. The State Emergency Operations Plan generally describes the roles and responsibilities of DMH/DD/SAS in a disaster event. Program design of the behavioral health response effort is related to the scope and nature of the disaster.

c. Within the disaster context, there is increased risk for adverse behavioral health outcomes such as acute anxiety, post traumatic stress syndrome, suicide, and substance misuse. The role of public behavioral health authority includes regulatory and service provision responsibility to:

- Provide supports, and assistance to achieve and support recovery.
- Prevent or reduce the frequency of disabling psychiatric conditions and substance misuse.
- Promote the behavioral health needs of all residents and responders.

d. The ability of DMH/DD/SAS to respond to meet disaster-related behavioral health needs is limited by resource constraints and the absence of specific budget authority to fund such services at the local or state level.

e. Recovery is enhanced by the availability of supportive assistance that normalizes emotional responses after a disaster while reducing maladaptive and adverse outcomes such as substance misuse, anxiety or depression.

f. In addition to the needs of the general population, it is recognized that some individuals are at greater risk of long-term adverse behavioral health effects post disaster. These individuals are often referred to as Special Needs Populations or Medically/Functionally Dependent by disaster response agencies. Generally, these populations are broadly defined and include persons with disabilities, particularly those with previously existing behavioral health conditions and those who are medication dependent such as people who use methadone and life sustaining medications. The

children and the elderly, persons who are homeless, individuals from diverse cultures with differing norms and rituals for grief, stress, loss, and other challenges associated with disasters are also included in this grouping. Individuals with histories of previous exposure to traumatic experiences (such as wartime refugee camps or other violence) may be at higher risk as well.

g. Disaster preparedness and response activities should also keep in mind those individuals of lower socioeconomic levels, migrant workers, people who use a language other than English or people who are not literate in English.

h. Interventions must be appropriate to the phase of the disaster. Disaster behavioral health responders must recognize the varying psychological reactions to be expected during each phase of the disaster. This is a component of the required disaster behavioral health training.

2. Assumptions

a. Although the large majority of individuals who are affected by a disaster experience emotional and stress reactions to the event, these reactions are normal and infrequently result in long-term adverse behavioral health outcomes. In the aftermath of terrorist events in this country, however, there is evidence that larger numbers of people are emotionally affected by the event and even those not considered as primary or secondary survivors experience significant levels of distress in the following days and weeks.

b. Disaster behavioral health programs and activities are designed to identify and provide outreach to individuals known to be at greater risk due to a disaster.

c. People who experience distress and symptoms after an event are unlikely to seek assistance from the behavioral health community and outreach is the most effective way to identify and offer needed supports to persons affected by a disaster.

d. Strong and prepared communities are most effective in providing caring and supportive responses to individuals impacted by a disaster event. Natural helping systems and information support structures such as families, faith communities, schools, affiliated volunteers, cultural centers, self-help groups, and service organizations can often provide a response equal to responses by paid helpers.

e. As the public behavioral health authority, DMH/DD/SAS has the leadership responsibility to plan for the behavioral health needs associated with disasters. Community preparedness and response will be carried out by the LME and/or their contract behavioral health providers.

f. Continuity of care for existing consumers and the ability to provide support in communities impacted by a disaster is critical. Providers that have prepared by developing sound and effective continuity of operations plans and strategies will be in the strongest position to mount an effective behavioral health service delivery response in their communities.

g. The local behavioral health infrastructure and disaster competent resources vary significantly from county to county. The Division encourages the use of interagency and regional agreements to supplement local resources and to plan for surge capacity in larger events.

h. Local behavioral health resources may be quickly overwhelmed in a significant disaster event and federal assistance may be required to mount a response. Deployment of technical assistance, public education and training related to behavioral health needs may be the extent of capability and resources for smaller events.

i. Integration of substance misuse prevention and treatment competencies into the behavioral health response effort is critical.

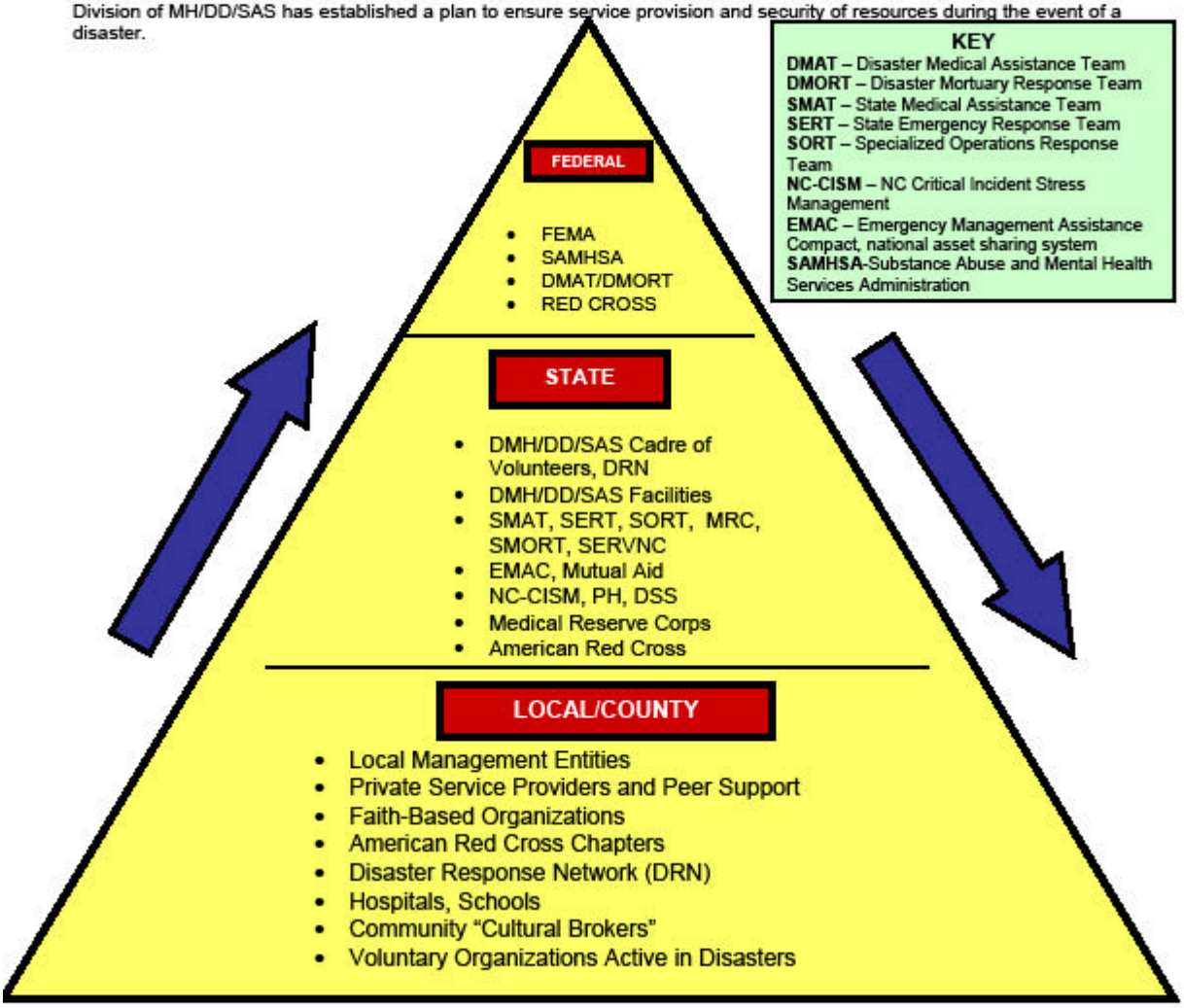
j. Behavioral health outreach is most effective when conducted in collaboration and partnership with the American Red Cross (ARC), Disaster Response Network (DRN), faith based disaster responders and Voluntary Organizations Active in Disaster (VOAD) and Critical Incident Stress Management Teams (CISM), local departments of social services and public health, and other community response partners.

II. CONCEPT OF OPERATIONS

The role of the disaster behavioral health responder, as well as the location and types of services that will be offered after a disaster event, are defined by the type and impact of the event. The disaster behavioral health response is community-based. Services may be provided in a shelter, disaster assistance center, medication dispensing site such as in a pandemic influenza event, and various locations throughout the community. During the immediate phase, providing support is often what is most needed. A disaster behavioral health responder may also need to do rapid needs assessments, provide immediate psychological first aid, and outreach, or even participate in death notification. The disaster behavioral health responder must respond with a recognized response agency. The pyramid below illustrates the traditional disaster behavioral health response agencies/partners at the local, state, and federal levels.

NORTH CAROLINA
DISASTER BEHAVIORAL HEALTH RESPONSE

The mission of the Division of MH/DD/SAS states that…*"North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice."* It becomes especially urgent with respect to ensuring that the state's overall preparation, response, and recovery efforts include activities that address the impact of disasters. In collaboration with local, state, and federal individuals/organizations, the Division of MH/DD/SAS has established a plan to ensure service provision and security of resources during the event of a disaster.



ALL DISASTER RESPONSE HAS A FOUNDATION IN THE LOCALCOMMUNITY

Should the lower tier (local/county) exhaust and/or exceed the local response capacity, State agencies are requested to provide additional support/assistance. The same applies should State resources become exhausted and a request for assistance is made at a Federal level. The tiers may build on each other in order to ensure that resources are available and appropriate in responding to and recovering from a disaster.

A. Roles and Responsibilities

1. Local Level-Local Management Entities Activities

Each of the 100 counties in North Carolina has a local Emergency Operations Plan (EOP) that specifies its local emergency management structure. This local plan may contain information about meeting the behavioral health needs of its residents. The LME will respond through the local Incident Command System.

The NC Department of Health and Human Services and its Division of MH/DD/SAS contracts with the local management entities (LMEs) to serve as the conduit for public behavioral health responsibilities and to coordinate the behavioral health response with their providers at the local level. LMEs may be structured as a one county program or as a multi-county area authority.

Each LME has a coordinator for disaster behavioral health preparedness and response. These coordinators serve as the link with local emergency management, local providers of MH/DD/SA services, local departments of public health and social services, and other agencies and organizations within communities, and with the Division of MH/DD/SAS. The LME coordinator is responsible for working with other local community response partners and for preparing a local disaster plan that is integrated with local emergency operations plans, the state disaster plan, and specifies how local providers and other agencies will work together. For example, in some counties the American Red Cross has a robust structure and may be called on by local emergency management to respond to the behavioral health needs of the impacted community. The LME needs to plan with the American Red Cross to determine the behavioral health response structure in the respective county so there is no duplication of services or worse yet, no services provided.

The LME disaster plan will contain the following elements of disaster preparedness and response:

a. Planning and Preparedness Activities.
b. Alert and mobilization.
c. Response.
d. Recovery.

a. Planning and Preparedness activities-include the time period before a disaster.

The LME will develop a behavioral health preparedness and response plan that integrates with the local and state plans. The LME shall encourage their contracted behavioral health providers to create disaster response plans that link with the LME's plan and may link with other local plans.

Both the LME and their providers will have a Continuity of Operations Plan to ensure provision of critical services during a disaster of any type as well as a plan to provide behavioral health services to the disaster affected community. Providers are required to have disaster plans that meet the requirements of their licensing and accrediting bodies.

The LME or its designee will:

- Have a disaster plan that is service-area-wide in its focus and addresses disaster preparedness and response on a county-by-county basis.
- Develop a mutual aid agreement with other LMEs and disaster response agencies to enhance their behavioral health capabilities.
- Ensure all who respond to a disaster from the LME or on behalf of the LME receive training in Incident Command System/National Incident Management System (ICS/NIMS) and disaster behavioral health response.
- Develop a local behavioral health response infrastructure with community response partners such as DRN, Red Cross, Salvation Army, NC Critical Incident Stress Management (CISM), Department of Social Services, Public Health, Peer Support, Cultural Brokers, Faith Based and other Volunteer Organizations Active in Disasters.
- Provide public education to MH/DD/SAS providers, consumers, and the community on the importance of individual and agency all hazards disaster preparedness plans.

b. Alert and Mobilization plans and activities-includes the time period immediately preceding a forecasted disaster. At this time, the LME is reviewing its response plan and making contacts with response partners.

The LME or its designee will:

- Notify LME staff and providers to go on alert;
- Notify DMH/DD/SAS of alert status;
- Determine need to deploy behavioral health resources or remain available via telephone;
- Deploy responders to shelters, Emergency Operations Center, Disaster Assistance Centers, or wherever the disaster response site is located.

c. Response plans and activities-include focus on the manner in which disaster MH/DD/SA services are provided from impact until the recovery phase begins. During this period, which generally lasts no more than six to eight weeks, resources from within the MH/DD/SAS system are dedicated to the affected areas until the crisis is resolved or federally supported crisis counselors are hired to take over the longer term services needed by survivors.

The two primary goals are: providing assistance in restoring the Local Management Entity; and stationing staff at congregate sites in the community where survivors are likely to be sheltered (if not previously deployed during the Alert and Mobilization phase) and where survivors will seek assistance (e.g., American Red Cross Disaster Response Centers).

In the immediate aftermath of a disaster event, the decision to deploy local behavioral health resources as part of the community response is a local decision. The decision will be based on the size, scope and nature of the disaster event as well as availability of disaster-competent workers and resources. Due to resource

limitations, DMH/DD/SAS does not guarantee payment or reimbursement of behavioral health resources deployed in response to a disaster.

The LME or its designee will:

- Ensure outreach and education to the public and MH/DD/SAS individuals.
- Ensure early intervention such as psychological first aid to individuals, families and responders; counseling of responders; and identification of people in need of longer term crisis counseling or mental health services.
- Coordinate assessment of needs of persons with disabilities.
- Provide culturally competent disaster behavioral health services.
- Work with local emergency management to ensure staff access to geographic areas impacted to assure continuity of services to community clients and program sites located in impacted zones.
- Work with community disaster response partners in providing disaster behavioral health services and include their peer support disaster behavioral health responders in delivery of services.
- Consider setting up a phone tree or other communication system with responders to keep individuals informed as to updates related to the disaster response.
- Communicate with DMH/DD/SAS regarding resource needs.
- Assign staff to needs assessment teams, early intervention teams, community relations teams, and disaster/incident hotlines.
- If deployed, coordinate outreach activities that will be consistent with the FEMA Crisis Counseling Program (CCP) model to increase likelihood of reimbursement if funded. Considerations include training and background of the outreach workers consistent with the FEMA CCP model.
- Assess the need to apply for the FEMA regular services grant;
- As warranted, request consideration for FEMA CCP.
- Assist in data gathering to support CCP application.
- Maintain data to support retroactive reimbursement under the FEMA Immediate Services Grant (ISG) for the grant application period if the application is successful. These efforts will integrate data regarding allowable activities and expenses consistent with FEMA CCP requirements.
- Evaluate need for any measures to provide staffing and service delivery in impacted areas where travel, supplies, communications, and support are disrupted.
- Consult with DMH/DD/SAS on the development of risk communication.

d. Recovery plans and activities- include ongoing response activities. Local and regional behavioral health personnel should be encouraged to join any long-term needs groups that may form in the affected area following disaster. LME disaster coordinator will report recovery needs and progress to DMH/DD/SAS. DMH/DD/SAS will monitor activities and needs of affected areas so it is in a position to advocate for resources and funding when they become available. Recovery activities may include the provision of crisis counseling services to survivors for a nine-month period via the FEMA Regular Services Grant (RSG). These services

are provided by full or part-time temporary staff, usually indigenous workers with trained and experienced clinical supervisors. These services are provided through outreach and in community settings where survivors live, work, go to school, and congregate.

In large-scale emergencies, trained provider staff may serve as a recruitment pool to work as crisis counselors in the FEMA program to help meet surge capacity needs. Recovery is a process that occurs over time for individuals and communities. Behavioral health needs in recovery are dependent upon a number of factors, including the pre-existing state of individuals and communities, the nature, scope, and severity of the disaster, and the type of assistance that is made available through formal response mechanisms. Generally, recovery is a local responsibility but there may be opportunities for assistance from federal and state resources to meet this responsibility. First responders may be aided in the recovery process through NC CISM services or contracted agencies. Declarations of disaster by the Governor may increase the likelihood of resources becoming available to the affected area to aid in recovery. Declarations of disaster by the President may create opportunities for public reimbursement for response activities and may create the opportunity to apply for the FEMA CCP.

The LME or its designee will:

- Assess need for RSG application for CCP.
- Conduct surveillance activities with response partners to monitor the recovery environment, provide triage and provide treatment if needed.
- The LME will implement approved RSG services utilizing a workforce that integrates substance abuse prevention and treatment competencies into its outreach services.
- Coordinate or provide CCP training consistent with the grant period.
- Coordinate media responses and public education requests as arranged or requested by local, state or federal disaster officials.
- Perform RSG administrative support functions, including monitoring and data analysis.
- As needed, the LME will provide support to DMH/DD/SAS as the Division develops the grant application and administers it as approved.
- LME will implement approved RSG.

e. Areas of Concern

- Sites Of Intervention

There are a variety of sites where behavioral health disaster responders may be needed. On an important note, behavioral health providers are often not needed at the site of the incident. Although it is a normal response to want to rush to these sites to be of assistance, the assistance that behavioral health responders provide will most likely be needed later, rather than at the time of immediate crisis. More importantly, these providers may impede the progress of rescue operations, and possibly place themselves at risk of injury.

LME coordinators should be prepared to deploy behavioral health disaster response workers to the following sites:

1) Where survivors and families gather
2) Shelters, meal sites, disaster application centers, ARC service centers, hospitals, schools, police stations, morgues, etc.
3) Mass care centers
4) Mass clinics for immunizations and/or prophylactic medications
5) Sites where first responders and other response workers gather (coordinate with state CISM)
6) Sites conducive to community education and outreach (community centers, shopping malls, schools, religious centers, business associations, newspapers, radio, TV, internet)
7) Organizations who request behavioral health response services (businesses, affected neighborhoods, farms or ranches).

- Special Populations

In disaster preparedness and response planning, it is important to think about disability from a broad perspective. The term disability does not apply just to people whose disabilities are noticeable, such as people who use wheelchairs and people who are blind, but also applies to people with hidden disabilities such as heart disease, emotional or psychiatric conditions, arthritis, significant allergies, asthma, multiple chemical sensitivities, respiratory conditions, hearing, intellectual and cognitive disabilities.

Traditional narrow definitions of disability are not helpful and not inclusive of other risk factors during a disaster. The term “special populations” involves a variety of individuals and groups who require additional measures in planning for disaster preparedness and response. Within the context of this plan, special populations will refer to multiple subgroups within the general population such as those listed above as well as people with substance use issues, individuals with diabetes or seizure disorders, people in a lower economic status, immigrants, people with limited language skills, and temporary limitations resulting from surgery, accidents, and pregnancy. Anyone can convert at any moment to having a disability particularly during emergencies. Preparing to accommodate people within a special population framework often translates into being better prepared to serve all people.

Special populations have a wide variety of communication, support and health needs and tend to live in low income areas that include areas at higher risk for disasters. Preparedness and response require communication activities with the capacity to reach every person. But to do this, a community must know what sub-groups make up their population, where the people in the groups live and work, and how they best receive information. The LME and their providers should strive to communicate the message of personal preparedness by providing information to all people within their geographic borders. Individuals within the special populations group should be included in local disaster planning efforts.

Some issues to consider in relation to disaster preparedness and response for individuals in the special populations group are:

1) Economically disadvantaged-many people with disabilities live at or below the poverty level. Extra help will be needed in evacuation.
2) Limited language competence-limited or no English speaking or reading/writing skills. Low literacy rates, and intellectual and cognitive disabilities. The Deaf community is served by the Division of Services for the Deaf and Hard of Hearing.
3) Disability-physical, mental, sensory, intellectual, cognitive. Health conditions that affect mobility or make them electricity dependent or medically dependent.

- Liability

The Good Samaritan Act (N.C. Senate Bill 160) can be applied to protect behavioral health responders as long as they operate within their scope of training and responsibility. This is not a substitute for legal advice regarding liability. There is no liability protection for responders who engage in illegal or unethical behavior while responding.

- Non-Affiliated Volunteers

The LME and official disaster response agencies have responders who are trained and recognized as behavioral health responders. However, non-affiliated volunteers may self-deploy and offer their services. The LME has the choice of using these responders by providing "just-in-time training", or encouraging them to obtain training before responding to the next disaster. Lack of training in disaster behavioral health can result in use of interventions and strategies that are not evidence-based and may cause emotional harm for some individuals.

2. State Operated Healthcare Facilities Preparedness Activities

State Operated Healthcare Facilities are local/regional providers of services but are also considered to be state assets. They shall have primary responsibility in an emergency event to care for their patients or residents, employees, and any visitors on campus at the time. However, it is recognized that the unique assets and competencies available in a facility may be valuable resources to the community or to MH/DD/SAS providers. When sharing resources does not impede the facility's mission to provide care to its own patients or serve a broader need, resources may be offered for use in community behavioral health response to the event.

Each facility shall:

- Have a disaster plan that meets the requirements of their accrediting organizations.
- Work from a Business Continuity Management System of updating annually their Business Impact Analysis, Risk Assessment, Business Continuity/Disaster Recovery Plans, Emergency Operations Plan, and Continuity of Operations Plan. These plans should be based on an "All-Hazards" approach and will include responses to natural, biological, human caused and pandemic influenza events.
- Include lists of primary staff contacts and their telephone/fax numbers and e-mail addresses by which those staff members may be reached. The lists shall also

include back-up staff contacts who may be contacted in the absence of the primary staff contact persons. Staff contact persons should be designated as administrative/support staff or clinical staff. These lists shall be updated, at least, once per year.

- Develop lists of staff that can be called upon, in the event of a disaster, to provide assistance to other facilities and Local Management Entities. Staff on the lists shall be separated into those with administrative/support skills and those with clinical skills. These lists should be updated, at least, every six months and provided to the Division Coordinator of Disaster Preparedness, Response and Recovery.
- Describe how the facility relates to and works with local Disaster Response Teams.
- Include a plan for sheltering in place, partial evacuation of the facility to an unaffected part of the complex or to another facility.
- Include a plan for the complete evacuation of the facility to another suitable, identified facility.
- Include instructions for housing evacuees from other facilities and community programs on an emergency basis.
- Provide guidelines to ensure that adequate staffing will be present in the facility to continue daily operations of each affected facility. This is especially important when designated staff members for those facilities are called to the field to provide early intervention, damage assessments, or other needed services during or after a disaster.
- Review, exercise, and update their disaster plan at least annually and involve all staff in the process. When possible, it is recommended that the review and updating of disaster plans be conducted soon after a disaster, while the experience is still fresh in the minds of those who responded.
- Assign an individual to oversee disaster response and develop an ICS structure.
- As allowed, participate in entering data into the State Medical Asset Resource Tracking Tool as part of the National Disaster Medical System response and participate in the Regional Advisory Committee meetings.

3. State Level Preparedness Activities

State level coordination of resources during a disaster occurs only when local and regional resources are inadequate or overwhelmed. DMH/DD/SAS is responsible for maintaining capacity and readiness on the state level to assist communities in meeting their behavioral health needs following a disaster. If the LME needs additional responders, DMH/DD/SAS has developed and maintains a cadre of responders trained in disaster behavioral health response. The State Office of Emergency Medical Services (OEMS) also has a web site (SERVNC.ORG) dedicated to medical activation in the event of an emergency.

a. Pre-event Preparedness/Planning

- Fosters and/or makes available information about training opportunities related to psychological first aid and personal and agency preparedness.
- Builds relationships with public health officials, community stakeholders, schools, and non-governmental organizations.

- Prepares public education and risk communication template.
- Update DMH/DD/SAS disaster web site.
- Maintains a cadre of trained behavioral health professionals.
- Reviews disaster preparedness and response plan annually.
- Participate in agency and statewide disaster exercises and/or training.
- Reviews current contact information and activation mechanisms for American Red Cross, DRN, Critical Incident Stress Management, and Voluntary Organizations Active in Disasters that provide statewide disaster assistance related to meeting the psychological and or social needs of those touched by disaster.
- Makes key contacts with LME disaster behavioral health coordinators.
- Ensures copies of the resource notebook for the DMH/DD/SAS response team are updated annually and are located at NC EOC and DMH/DD/SAS for ease of access during an emergency situation.
- Monitors communications from NC EOC regarding any threats or warnings
- Receives health alerts to monitor health and public health conditions and surveillance.
- Maintains lists of emergency contacts for state operated healthcare facilities and LMEs for immediate notice and assistance in an event.
- Alerts LMEs of the possible need to activate behavioral health response, when advance preparation is possible.

b. Alert and mobilization

Activation of State Emergency Operations Center

- DHHS is the primary public agency for health and medical care. DMH/DD/SAS is a support agency and is subject to activation by DHHS and State Division of Emergency Management as warranted.
- The DHHS Office of Citizens Services notifies the Division's Disaster Preparedness and Response Coordinator, Division Director, OSS Section Chief, and Planning Team Leader of disaster activation. All have the authority to activate the Plan.
- When such notification is issued, the Disaster Coordinator will notify the Division's EOC back up responders to schedule EOC coverage.
- All Section Chiefs of the Division of MH/DD/SAS will develop and update a list of their staff's' telephone numbers, pager numbers, home addresses, fax, and e-mail addresses and send to the Disaster Preparedness and Response Coordinator at least twice a year.
- The Disaster Preparedness and Response Coordinator will update the list of the EOC responders' telephone numbers, pager numbers, home addresses, and e-mail addresses annually or as needed.
- All EOC response members will be temporarily relieved by their respective Section Chiefs of most of their regular duties except the most urgent responsibilities in order to provide the time necessary to respond to the disaster event.

- EOC responder will serve as liaison and will be authorized to identify and deploy resources of the Division for disaster response and recovery efforts.

As a member of SERT, the Division will coordinate with other components of state and local government agencies to include law enforcement, fire and rescue, emergency medical services, victim services, agriculture, public health, social services, child development, schools, and aging and adult services. The Division will also coordinate response and assets with VOADs such as the Red Cross, DRN, Salvation Army, Wake Interfaith Disaster Team, etc.

The Division of Emergency Management has different alerts levels for activation of the state EOC. Please refer to Appendix C for the State EOC plan web site. When activated, the Disaster Preparedness and Response Coordinator will schedule shift coverage with co-workers to staff the behavioral health desk at the EOC for as long as the EOC is at full activation level. DMH/DD/SAS has its own EOC located in the Albemarle building that may be used as a back up to the State EOC.

Establishment of the MH/DD/SAS EOC
The MH/DD/SAS EOC will be activated for small events that do not warrant a full scale state activation. The MH/DD/SAS EOC will be staffed 24 hours a day, if necessary, or for as long as the response requires. Several telephones, a TTY machine (for the Deaf and Hard of Hearing), a fax machine, and at least two computers will be available in the MH/DD/SAS EOC. The computer will have connectivity with the State WEB EOC.

Communication
The DHHS Public Information Officer (PIO) will have responsibility for coordinating requests for information related to the behavioral impact of the disaster event. The PIO will also review and comment on prepared messages that the DMH/DD/SAS Director, Executive Leadership Team, or the Disaster Preparedness and Response Coordinator will deliver regarding behavioral health issues, as needed, post disaster.

Preparedness and psychosocial education materials are available on the Division's website. In addition, examples of public information material from other states used in disaster response efforts have been collected from the Substance Abuse Mental Health Services Association Disaster Technical Assistance Center (DTAC) and other resources to be used as templates and models for material to be disseminated in North Carolina. The information will be disseminated in electronic format and posted on the website for rapid access in an emergency.

c. Response Phase

- Initiate contact with LMEs in affected areas to gather data about cultural issues and special needs populations affected by the event.

- Provide technical assistance, consultation and training to LME and their providers as requested.
- Work with LME and Office of Citizen Services to identify sources for translators.
- Monitor situation for needs assessment and collaboration.
- Monitor status of disaster declaration and immediately communicate with the LME when declarations are requested and made.
- If warranted and with authorization of the Governor's Authorized Representative, DMH/DD/SAS will develop a written CCP application. The plan will include consideration of substance abuse needs, special needs population, use of indigenous workers, cultural issues and interpreter/translation services for impacted communities.
- DMH/DD/SAS, with the affected LME will determine the need for the FEMA IS CCP grant.
- Participate in conference calls with FEMA, NC Emergency Management, LME, Disaster Response Network, VOAD, etc.
- Coordinate mutual aid agreements with other states in respect to disaster response.

d. Recovery Phase

This phase begins when either the Local Management Entities return to normal operations and provide long-term crisis counseling services to survivors, or response teams are replaced by temporary full-time crisis counselors. In a Presidentially declared disaster, these counselors will be hired with funds from FEMA, administered through the Center for Mental Health Services. In the event the disaster is not a presidentially declared disaster, the DMH/DD/SAS may get funds from State Emergency Response Grant (SERG) application through SAMHSA. If the level of need does not reach SERG requirements, the DMH/DD/SAS may have to support within available resources the hiring of full-time temporary crisis counselors, if providing this service to survivors is beyond the existing financial capacity of the affected Local Management Entities.

- The NC Division of Emergency Management, DHHS, and DMH/DD/SAS collaborate at the state level to establish expectations and infrastructure for effective behavioral health response to a disaster.
- DMH/DD/SAS will coordinate support with LMEs and the federal Government.
- DMH/DD/SAS will participate in disaster recovery partnership activities, cooperate with and coordinate any federal on-site visits or audit activities, conduct data collection, evaluation, after actions, and grant close-out activities, and will maintain CCP grant files consistent with federal requirements.
- Participate in the Immediate Services and Regular Services phases of the FEMA Crisis Counseling Program by deploying staff and providing outreach services consistent with federal requirements as outlines in appendix E under web resources.

- Establish pre-planned plans with a subcontract agency to implement IS and RS phases of the FEMA CCP.
- Demonstrate the availability of local funding and resources to implement a program equal or great in size and scope with the Immediate Services and Regular Services phases of the FEMA CCP. Request approval, in advance of implementation, to redirect Purchase of Service funding within an agency's existing allocation to meet the disaster-related crisis counseling needs of the affected community or communities.

4. Voluntary Organization Level

Volunteer agencies provide immediate and diverse services after a disaster. The Voluntary Organizations Active in Disaster (VOAD) is comprised of many different response partners such as interfaith groups and nonprofit organizations who respond to disasters as part of their overall mission. The Disaster Response Network, under the auspices of the North Carolina Psychological Foundation (NCPF), is an organized disaster response agency involving psychologists, as well as psychiatrists, licensed clinical social workers, licensed professional counselors, certified psychiatric nurses and licensed marriage and family therapists, in disaster response throughout North Carolina.

DMH/DD/SAS will work the LME, ARC, DRN, NC CISM and VOADs to identify and deploy appropriate resources to the affected area. Once the disaster progresses through the response phase toward recovery, DMH/DD/SAS will work with LMEs to identify recovery needs related to behavioral health in the affected area.

American Red Cross

According to their agreement with the National Transportation and Safety Board (NTSB), the ARC is responsible for responding to all of the behavioral health needs of survivors of an airplane incident.

Emergency Responder Support

Activities to support emergency responders are critically important to their wellbeing and effectiveness in an emergency. While no formal agreements with DMH/DD/SAS are in place, the NC Critical Incident Stress Management Team is activated by the Division of Emergency Management to provide supportive services to first responders. The LME may provide support on a local level.

B. General Sequence of Actions

1. Guidelines for Activating the State Plan

The following are general guidelines. In all instances, the magnitude of the disaster shall be the determining factor regarding the response of the Division of MH/DD/SAS. Local Management Entities and State operated healthcare facilities are expected to be proactive in assessing whether they need to respond to a local incident and in advising the Division of MH/DD/SAS regarding the need for outside assistance.

- Community Incidents/Emergency Situations:

In situations where a small group of individuals in a community and/or in a portion of a State operated healthcare facility are affected by a traumatic event in one county, it is the responsibility of the Local Management Entity and/or State operated healthcare facility to activate its disaster plan. When the plan is activated, the Local Management Entity and/or State operated healthcare facility should notify the DMH/DD/SAS Disaster Preparedness and Response Coordinator. In these situations, casualties and property losses are minimal and response is generally within the capability of the Local Management Entity and/or State operated healthcare facility.

- Small Scale Disasters:

When one or two Local Management Entities with two to four affected counties, and/or one entire State operated healthcare facility are affected by a disaster, this would qualify as a small-scale disaster. The responsibility for alert, response and recovery remains with the Local Management Entity and State operated healthcare facility, though Division of MH/DD/SAS assistance may be needed. State level assistance would be available for technical assistance, deployment of outside assistance and possibly other necessary supports. Local Management Entities and State operated healthcare facilities are responsible for activating their disaster plans and for notifying the DMH/DD/SAS Disaster Preparedness and Response Coordinator. If invited, Local Management Entity staff should immediately be deployed to county EOCs to monitor the impact of the disaster and to keep local and state staff advised of developing issues and needs.

- Large Scale Disasters:

Any Presidential Declaration of Disaster or three or more Local Management Entities, with five or more disaster-affected counties constitute a large-scale disaster. The Division of MH/DD/SAS, Local Management Entities, and may include State operated healthcare facilities will automatically activate their respective plans. Immediate contact should be made with the DMH/DD/SAS Disaster Preparedness and Response Coordinator. At the request of affected Local Management Entities or State operated healthcare facilities, the Division of MH/DD/SAS will assist the LME in the deployment a needs assessment team(s). The needs assessment will form the basis for determining the resources and support needs of the affected MH/DD/SAS system and area.

C. Requesting Assistance

Local emergency management notifies NC Emergency Management that area resources in disaster behavioral health are overwhelmed and that additional assistance form the State is required. NC EM follows the protocol laid out in the State EOP and notifies DMH/DD/SAS that State involvement is needed to support the behavioral health response in the affected area.

Recovery Needs Assessment

Local entities are tasked with conducting an initial assessment of the behavioral health needs of individuals and the community affected by the disaster. The LME will work with local resources to track the scope of the response from its onset including number and type of behavioral health resources deployed. The LME, in consultation with local resources, will notify local emergency management if the disaster type, size or scope overwhelms the ability of local and regional resources to adequately respond to the behavioral health needs of those affected by the disaster. The LME should also notify DMH/DD/SAS of this decision so that locating additional resources can begin. DMH/DD/SAS will receive the official request for additional resources through the emergency management system. Needs assessment tools are available online at the following site:
www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/progguide.asp.

Mutual Aid Agreements

Local

The LME will be encouraged to develop mutual aid agreements with other LMEs, both contiguous and distant for surge capacity in catastrophic and large scale events. Cooperative agreements with ADA providers may also take the form of mutual aid as determined by local structure and planning efforts. Agreements should be structured to address activation and reimbursement, including provisions related to grant funding. Mutual aid agreements are particularly critical when 24 hour or daily service delivery is essential to consumer well-being. Agencies that provide residential services or methadone services are strongly encouraged to establish mutual aid agreements for contingencies that would result in disruption of services or relocation of operations.

National

To request behavioral health resources from other states, the DMH/DD/SAS Disaster Preparedness and Response Coordinator sends a request to the ESF #8 Coordinator. The ESF #8 coordinator then contacts the director of NCEM who will follow the standard operation procedures for requesting assistance form other states. Although typically used for traditional emergency management needs (such as equipment, utilities, and other functions) during a federally declared disaster, Emergency Management Assistance Compact (EMAC) also provides a vehicle for requesting services across state boundaries that could be used to request assistance such as but not limited to:

- Behavioral health workers;
- Administrators and planners for grant development; and
- Public education/public information officers with expertise in behavioral health and risk communication.

Federal Grants

State Emergency Response Grant Application

The DMH/DD/SAS Disaster Preparedness and Response Coordinator will work closely with NCEM to determine if State resources are available for fund deployment of personnel. A State declared disaster may also place some state employees in a

position to respond either as part of the disaster behavioral health response or as part of an ARC response.
For situations that do not qualify for FEMA funding, application can be made to CMHS for assistance to provide behavioral health services.
When a federal disaster has not been declared and DMH/DD/SAS in conjunction with the local LME concur that federal support is needed, DMH/DD/SAS will contact SAMHSA and the Disaster Technical Assistance Center for current information regarding an Emergency Response Grant to get current application materials.

Presidential Declaration of Disaster-FEMA Crisis Counseling Grant
If a presidential disaster declaration makes individuals eligible for assistance, a FEMA CCT and AP grant must be applied for within 14 days of the declaration. The ISP Application covers the first 60 days of. RSP Application is due within 60 days of the presidential declaration and provides funds for an additional 9 months of services.

Crisis Counseling Services
These services will be provided by existing local staff when it is within their capacity to do so. If supplemental staff is needed, the following provisions apply:

1. The DMH/DD/SAS Disaster Preparedness and Response Coordinator will serve as project manager to implement and supervise a State supported program of counseling services, if funding permits, or the federally funded Immediate and Regular Services Grant Programs.
2. As a general guideline, FEMA funded crisis counselors will be people who are indigenous to the affected area and who are supervised by trained clinical staff.
3. The Recovery Phase will last from six (6) to twelve (12) months, depending on the needs.
4. The final 60 days of the project will focus on termination of counselors with their consumers and with their jobs.
5. The Focus of Services and Training of Crisis Counselors:
    a. Local crisis counselors will provide primarily home based and community based services; outreach will be an integral and primary means of reaching survivors. The DMH/DD/SAS Disaster Preparedness and Response Coordinator will ensure that crisis counselors are trained throughout their tenure. Appropriate training may be delivered by DMH/DD/SAS staff or by contract staff with special expertise.
    b. Crisis counselors will be trained to provide crisis counseling to local groups impacted by the event that served as responders and were also survivors. Crisis counseling training will emphasize the development of cultural competence.
    c. Services will be culturally appropriate and focus on active listening, normalization of emotional responses, problem definition and resolution, advocacy, linkage, support, affirmation, support network development or re-establishment, education, information and referral. Training will encompass such topics as cultural competence, active listening skills, basic counseling skills, typical and atypical responses to catastrophic events, issues unique to children and elderly, knowledge of available resources and how to access those, advocacy that supports consumers' access to services for which they are

eligible, active referral and follow-up principles, grief counseling principles, anger management, conflict resolution and defusing, education, and consultation techniques.

d. Priority populations will be children and their families, people in poverty, the elderly, persons with sensory and other disabilities, including developmental disabilities, persons with serious and persistent mental illness, and person who are at high risk for experiencing crises.

Within three (3) months after the conclusion of the Recovery Phase, an evaluation will be done of the plans and preparation, alert and mobilization and response and recovery phases to revise, refine, and improve the capacity of the Division of MH/DD/SAS to respond

Information on the FEMA Crisis Counseling Grant can be found on SAMHSA's website: http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/progguide.asp

III. BUSINESS CONTINUITY MANAGEMENT PROGRAM

The DMH/DD/SAS has developed a business continuity management program to ensure the continuation of critical functions in the event of a disaster. This program includes: a business impact analysis, a risk assessment, a business continuity/disaster recovery plan which mainly addresses information technology, a health and safety plan, and a continuity of operations plan with a pandemic influenza annex. The state operated health care facilities have also instituted this business continuity management program. Access to this program information is restricted due to the confidential information it contains.

After a disaster, meeting the needs of those already in the behavioral health system must be a priority. A plan for continuity of services is primarily the responsibility of the service provider, facility, or LME. Providers may be called on to respond to individuals who are not in the behavioral health system while at the same time they need to provide services for the individuals they serve. In some situations, however, current service provision will need to be augmented with disaster behavioral health services. Service providers should recognize when their individuals are affected by a disaster and request additional resources when needed from the LME.

The LME and service providers are encouraged to develop a robust business continuity management program. Although not exhaustive, a brief description for this program is provided below.

A. Business Impact Analysis (BIA)

- Looks at how an emergency event would impact the agency's ability to fulfill its mission.
- Identifies critical business functions.

- Critical doesn't mean more important but instead means how the agency would be significantly impacted if the employee could not do the business function.
  - Identifies time-critical functions, their recovery priorities, and inter-dependencies so that recovery time objectives can be set.
  - Risk evaluation and control determines the events and external surrounding that can adversely affect the organization and its resources with disruption as well as disaster, the damage such events can cause, and the controls needed to prevent or minimize the effects of potential loss.

B. Risk Assessment

When developing strategies for a continuity plan, consider the entire range of probable and possible threats that present a risk to the organization. From that range of threats, likely scenarios can be developed and appropriate strategies applied.

C. Business Continuity/Disaster Recovery Plan (BC/DRP)

- Business continuity looks at what is needed to keep the "business" going in an emergency event.
- Disaster Recovery is the step-by-step process for bringing information technology systems back to operational status after an emergency event.
- The BC/DR Plan is dependent upon information obtained in the BIA.

D. Health and Safety Plan

- The emergency response plan is an organized plan for response and stabilization of a situation following an incident or event, and is known by many names (Emergency Operations Plan, Facility Disaster Plan, etc.)
- This includes the evacuation plan, work place violence plan, communicable disease plan, etc.

E. Continuity of Operations Plan (COOP)

The objective of the COOP is to direct and guide appropriate actions to reduce disruptions to operations, protect essential equipment, records, and other assets, provide organization and operational stability, facilitate decision-making during an emergency, and achieve an orderly recovery from emergency operations.

Each LME/provider will consider and plan for critical personnel and logistical issues in the event any hazard would potentially disrupt operations for their employees and the people they serve. Among these considerations are:

- Identification of essential functions and personnel.
- Arrangements for support needs for employees and clients (food, water, medications, transformation, etc).
- Provision for self-support or shelter in place for up to 72 hours.
- Availability, transport, administration, and privacy of clinical and service delivery records.
- Evacuation to alternate sites.
- Replacement or repair of damaged or destroyed equipment.

- A pandemic influenza addendum should be added to the COOP plan to also address reduction in staff, social distancing, orders of succession and devolution.

The COOP plan should also address communication interoperability such as landlines, fax, cell phone, pager, satellite phone, email and internet. Other options for communications could include the United States Postal Service, United Postal Service courier services, radio, ham radio and web sites for access to information when traditional communications are down.

These and other disaster recovery and business continuity issues should be incorporated into an established agency plan. Models and guidance for development of sound plans can be found at websites for FEMA and OSHA as well as other locations on the internet. The LMEs can use the August 2006 LME template with a provider section for a guide to continuity of operations planning.

IV. APPENDICIES

A. North Carolina Emergency Operations Plan

http://www.nccrimecontrol.org/div/EM/documents/NCEOP-2009-PublicVersion.pdf

B. Glossary

American Red Cross (ARC) – A humanitarian organization led by volunteers and guided by its Congressional Charter and the Fundamental Principles of the International Red Cross Movement that provides relief to survivors of disasters and help people prevent, prepare for, and respond to emergencies.

Community Health Assessment Team (CHAT) – A multi-disciplinary group, formed by the Department of Health and Human Services, including staff from the Divisions of Social Services, Mental Health/Developmental Disabilities/Substance Abuse Services, Public Health, and Emergency Management, that provides individual screening of needs immediately following a disaster, referral to needed resources, and disaster recovery information to survivors.

Community Relations Team – The role of a Community Relations Team is to provide a visible presence of support within the disaster area. Community Relations Teams are deployed within the disaster area, assessing the magnitude of impact upon the community as well as providing community leaders and residents information of the disaster assistance process and assistant programs. The Teams are typically composed of a Federal Emergency Management Agency representative and one or more representatives from state agencies, including staff from the Department of Health and Human Services.

Crisis Counseling Program (CCP) – FEMA funded grant program to provide crisis counseling to survivors of a disaster, within either a 60 day period or a 9 month period, following the disaster occurrence.

Disaster Response Center (DRC) – The primary entity for delivery of assistance to individual disaster victims. It is set up by local government. The DRC is a one-stop processing center for individuals to apply for many government disaster relief programs.

Disaster/Emergency – A disaster and an emergency can both be described as any natural or human-caused event, which threatens or causes excessive morbidity, mortality, and/or loss of property. Disaster and emergency are used interchangeably whenever a situation calls for a crisis response. However, emergencies can be handled with resources that are routinely available to the community. A disaster calls for a response and resources that exceed local capabilities.

Disaster Field Office (DFO) – The office that is established in or near the designated area to support Federal and State response operations.

Early Intervention (from National Institute of Mental Health, 2002) – The provision of psychological help to victims/survivors within the first month after a critical incident, traumatic event, emergency, or disaster aimed at reducing the severity or duration or event-related distress. For mental health service providers, this may involve psychological first aid, needs assessment, consultation, fostering resilience and natural supports, and triage, as well as psychological and medical treatment.

Emergency Management (EM) – The organized analysis, planning, decision-making, and assigning and coordinating of available resources, for the purpose of preparing for, responding to, or recovering from major community-wide emergencies and disasters.

Emergency Medical Services (EMS) – Local medical response teams, usually rescue squads or local ambulance services that provide medical services during a disaster.

Emergency Operations Center (EOC) – A protected site, from which government officials and emergency response personnel exercise direction and control in an emergency. The Emergency Communications Center is usually an essential part of the EOC.

Emergency Support Functions (ESF)- Is a grouping of governmental and certain private sector capabilities into an organizational structure of 15 areas to provide support, resources, program implementation, and services that are most likely needed to save lives, protect property and the environment, restore essential services and critical infrastructure, and help victims and communities return to normal following domestic incidents.

Federal Emergency Management Agency (FEMA) – An independent agency of the federal government, which reports to the President. The agency's mission is to "reduce loss of life and property and protect our nation's critical infrastructure from all types of hazards through a comprehensive, risk-based, emergency management program of mitigation, preparedness, response, and recovery."

Immediate Services Program (ISP) – A grant award, from FEMA to a state, to provide crisis counseling to survivors of a disaster within a 60 day period, following the disaster occurrence.

Major Disaster – As defined under P.L. 93-288, a major disaster is any natural catastrophe, (including any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mud slide, snowstorm, or drought), or regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act, that serves to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

Mass Care – Mass Care consists of activities to provide shelter, feeding, first aid and distribution of relief supplies to disaster survivors, following a catastrophic natural disaster or other catastrophic event.

Memorandum of Understanding (MOU) – A document that is negotiated between organizations or legal jurisdictions, for mutual aid and assistance in times of need. An MOU usually contains information on organizational structure and responsibility, assigned or delegated authority, financial considerations (who pays for the expense of operations), liability (who is liable for personal or property injury or destruction during response operations), and commercial considerations (appropriate statements of non-competition of government resources with private enterprise).

Mental Health Treatment – Includes professionally conducted assessment, therapies, and treatment that are provided to persons who usually qualify for or already have a mental health diagnosis.

MH/DD/SAS Emergency Operations Center (MH/DD/SAS EOC) – The center for coordinating statewide mental health response and recovery activities following a disaster. The Disaster Response Team operates from this center.

Mitigation – Actions and activities directed toward eliminating or reducing the risk of disaster occurrence or sequelae. Mitigation may include changes in land use management; safety and rules and regulations; building codes/specifications; flood proofing; and disseminating information to the public.

Mutual Aid Agreement – A formal or informal understanding between jurisdictions that pledge exchange of emergency or disaster assistance.

Needs Assessment Team – A group of mental health professionals, led by a member of the Disaster Response Team, who are sent to disaster-affected areas to determine the needs of the local mental health/developmental disabilities/substance abuse service programs as well as the mental health needs of the survivors of the disaster.

North Carolina Emergency Operations Plan (NCEOP) – The State plan designed to cover all natural and man-made emergencies and disasters, which threaten the State.

Operational Debriefing (from National Institute of Mental Health, 2002) – A routine individual or group review of the details of an event from a factual perspective, for the purposes of:

- Learning what actually happened for the historical record or planning process,
- Improving future results in similar missions, and
- Increasing the readiness of those being debriefed for further action.

Operation debriefings are conducted by leaders or specialized debriefers according to the organization's standard operating procedure.

Preparedness – Activities that facilitate disaster response to save lives and minimize damage. These include the development of shelter and evacuation plans; the establishment of warning and communication systems; the training of emergency response personnel; and the conducting of tests and exercises.

Psychological First Aid (from National Institute of Mental Health, 2002) – Pragmatically oriented interventions with survivors or emergency responders targeting acute stress reactions and immediate needs. The goals of psychological first aid include the establishment of safety (objective and subjective), stress-related symptom reduction, restoration or rest and sleep, linkage to critical resources, and connection to social support.

Recovery – Assistance provided to return a community to normal or near-normal conditions. Short-term recovery returns vital life-support systems to minimum operating standards. Long-term recovery may continue for a number of years after a disaster and seeks to return life to normal or improved levels. Recovery activities include, temporary housing, loans or grants, disaster unemployment insurance, reconstruction, and counseling programs.

Regular Services Grant (RSG) – A grant award, from FEMA to a state, to provide crisis counseling to survivors of a disaster within a nine month period, following the termination of an Immediate Services Project.

Response – Activities that occur immediately before, during, or directly after an emergency or disaster. This includes lifesaving actions, such as the activation of warning systems, staffing the EOCs, implementation of shelter or evacuation plans, search and rescue, and provision of emergency medical services.

State Emergency Response Team (SERT) – A team of senior representatives of state agencies, state level volunteer organizations, and state level corporate associations who have knowledge of their organizations' resources and have the authority to commit those resources to emergency response. SERT operates from the State EOC and the Director of EM serves as the SERT leader.

Support Agency – A State department or agency that is designated to assist with available resources, capabilities, or expertise in support of the Emergency Support Function response operations, under the coordination of the Primary Agency.

C. List of Acronyms

ACF	Administration for Children and Families
AMCITS	American Citizens
ARC	American Red Cross
CISM	Critical Incident Stress Management
CCP	Crisis Counseling Program
CCPS	Crime Control and Public Safety
CDC	Centers for Disease Control

COOP	Continuity of Operations Plan
HHS	Department of Health and Human Services
DMAT	Disaster Medical Assistance Team
EOC	Emergency Operations Center
EMAC	Emergency Management Assistance Compact
ERT	Emergency Repatriation Team
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Association
HUD	Department of Housing and Urban Development
LME	Local Management Entity
MOU	Memorandum of Understanding
NERP	National Emergency Repatriation Program
ORR	Office of Refugee Resettlement
RDU	Raleigh Durham International Airport
RDUAA	Raleigh Durham Airport Authority
RPC	Repatriation Processing Center
RTM	Repatriation Team Manager
SAMHSA	Substance Abuse and Mental Health Services Administration
SEMA	State Emergency Management Association
TSA	Transportation Security Administration

D. References

National Institute of Mental Health (2002). *Mental health and Mass Violence: Evidence-Based Early Psychology Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices.* NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office.

Mental Health All-Hazards Disaster Planning Guidance
http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3829/default.asp

E. Web Resources

Division of Mental Health/Developmental Disabilities/Substance Abuse Services
http://www.ncdhhs.gov/mhddsas/disasterpreparedness/index.html

NC Department of Health and Human Services
http://www.dhhs.state.nc.us/

FEMA Crisis Counseling Grant
http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/progguide.asp

FEMA Continuity of Operations Planning
http://www.fema.gov/government/coop/index.shtm

National Disaster Medical System
http://www.hhs.gov/aspr/opeo/ndms/index.html

Federal Department of Health and Human Services
http://www.hhs.gov/disasters/

Substance Abuse Mental Health Services Administration
http://www.samhsa.gov/

Centers for Disease Control
http://www.cdc.gov/

American Red Cross
http://www.redcross.org/

National Center for Post-Traumatic Stress Disorder
http://www.ptsd.va.gov/

The National Child Traumatic Stress Network
www.nctsnet.org

NCPA Disaster Response Network
http://www.ncpsychology.com/html/Disaster%20Response%20Information.htm

National Voluntary Organizations Active in Disasters
www.nvoad.org